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## PRIMARY CARE DIRECT PATIENT CARE TIME

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive establishes the requirement that VHA Primary Care Practices enter data about Primary Care Provider (PCP) resources into the Primary Care Management Module (PCMM) using the standardized rules provided in Attachments A and B.

## 2. BACKGROUND

a. This Veterans Health Administration (VHA) Directive requires the entry and transmission of two key fields of information related to PCP resources. The first field, Primary Care Direct Patient Care (PCDPC), is the amount of time each PCP spends providing direct patient care to outpatients. PCDPC is defined as the time to prepare, provide for, and follow-up on the clinical care needs of outpatient, primary care patients. The second field is the expected maximum panel size that has been established for each PCP's panel. It represents the total maximum number of patients each PCP is expected to care for on their panel. **NOTE:** *The maximum expected panel size is set locally based on a host of factors known to affect panel size.*

(1) The PCDPC data and maximum panel size is required to be entered into PCMM before May 23, 2003. PCDPC is entered into the PCMM field, "Direct PC FTE" (404.52, .09) and maximum panel size is entered into the PCMM field, "Patients for Position: Allowed" (404.51, .08).

(2) Transmission of this data to the Austin Automation Center (AAC) is in process. The data will then be sent to the National Health Care Practitioner database for calculating national primary care patient capacity.

b. This VHA Directive builds on past directives that have required PCPs to use the Department of Veterans Affairs (VA's) PCMM Software to assign patients to PCPs as part of the management of Outpatient Primary Care. PCPs manage the overall care provided to the majority of veterans in the VA Health Care System and, as such, govern the total number of patients that can be cared for in the system. In response to the growing numbers of veterans wanting to use VA health care services, there is pressing need to quantify the primary care patient capacity that is available so that demand and supply can be better aligned.

c. Primary Care Capacity is quantified using two metrics contained in PCMM. The first is the maximum panel size expected for each providers panel - PCMM field: "Patients for Position: Allowed" (404.51, .08). This number is determined locally, based on negotiations between local providers and management. It is recognized that panel sizes vary depending on such factors as the disease burden of the patients on the panel, the number and types of support staff, the number of exam rooms, and the time available for direct patient primary care. Maximum panel size, when aggregated, represents the actual primary care capacity that is available in the system.

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d. PCDPC–PCMM field: “Direct PC FTE” (404.52, .09) represents the time that each PCP has available to take care of the patients on their panel. Time is represented as a percentage of a full-time FTE. This number is used to quantify a national standardized primary care capacity. It is derived using national standard expected panel sizes, to be adjusted for such factors as the differences in the disease burden of the panel and the degree of reliance on VA medical services. This number also provides valuable information on the apportionment of PCP Time between direct patient care and other duties.

e. It is imperative that the recording of this primary care capacity be done in a standardized and consistent way throughout the VA Health Care System. A national roll-up of this information is not meaningful unless each site follows the same standardized rules for recording this information. The PCDPC Guidelines reflect the method chosen by a group of physicians and PCMM coordinators after a great deal of deliberation and discussion. These guidelines reflect the agreed upon standardized rules, and it is critical that sites follow the standardized rules provided in this document when recording information relating to PCDPC Time.

f. PCMM PCDPC Time is not intended to represent the time spent exclusively doing hands-on primary care. Other activities are included in this time, as defined in the appendix, such as attending time spent in clinic. Since residents are not considered primary care clinicians, and patients followed by residents will be attributed to the attending, panel size comparisons within or across sites may be skewed by the contribution of the resident’s panel to the total patients recorded for the attending’s panel.

g. The PCMM is enhanced to collect PCDPC Time in a new field called Direct Primary Care (PC) FTE. This field will collect information on the amount of time, expressed as a percentage of a full-time, 40-hour FTE, that each PCP spends in providing primary care to their primary care panel. PCDPC includes all time spent in reviewing patient data, discussions about the care with colleagues, reviewing the medical literature, and contacting the patient or caregivers to discuss their needs.

h. The PCDPC Guidelines, found in Attachment A, are business rules written to assist in establishing a uniform method of documenting primary care time within the VHA network.

i. The PCP assumes responsibility for planning, coordinating, and ensuring continuity of care for the patient including maintenance of health and treatment of illness. Only medical doctors, doctors of osteopathy, nurse practitioners or physician assistants can be designated as PCPs. Other clinicians on the primary care team, e.g., residents, social workers, dietitians, podiatrists, nurses, Associate Providers (AP), and administrative personnel are not to be identified as PCPs; therefore, the “Direct PC FTE” is not entered for these positions. The PCMM FTE Report lists all PCPs and is used to identify clinicians and administrative personnel, who incorrectly have the “Can Provide Primary Care?” box checked. All non-PCPs must have this box unchecked or they will be erroneously included in the site’s PCP count.

**3. POLICY:** It is VHA policy that, for each PCP, the amount of time spent in providing direct patient care to their panel of primary care outpatients, PCDPC must be entered in the “Direct PC FTE” field (404.52, .09) in VistA PCMM and transmission will begin when the Direct Primary

Care Direct Patient Care Time has been populated. Primary Care Direct Patient Care Time is to be constructed for each PCP using rules defined in Attachment A.

#### 4. ACTION

a. **VISN Chief Medical Officer.** The VISN Chief Medical Officer has oversight responsibility for ensuring the Chiefs of Staff, or the equivalent service line managers, enforce the requirements in this directive. The Chiefs of Staff are responsible for ensuring that valid “Direct PC FTE” and “Maximum Panel Size” data is entered for each PCP in PCMM by May 23, 2003.

b. **Network Directors.** Network Directors must ensure that the PCMM Software is maintained and updated on all medical centers' VistA systems, in accordance with nationally distributed software and software patches.

c. **Facility Directors.** The local facility Directors are responsible for:

(1) General monitoring of the transmission of “Direct PC FTE” and “Maximum Panel Size” data at regular intervals through the use of the “PCMM HL7 Transmission” option, “PCMM Reject Transmission Menu options,” Messaging Mail Groups for transmission status, checking the logical link for the HL7 messages, and checking the transmission queue.

(2) Ensuring that:

(a) “Direct PC FTE” and “Maximum Panel Size” data is entered for each PCP in PCMM by May 23, 2003.

(b) The maximum panel size, “Patients for Position: Allowed” field (404.52, .09) is entered for each PCP in the PCMM by May 23, 2003, and is transmitted to AAC.

(c) Additions and changes in the “Direct PC FTE” and primary care panel sizes, Patients for Position: Allowed” field (404.51, .08) is transmitted to the AAC every night.

(d) Institutions entered in PCMM are in the nationally available Institution file (4). ***NOTE:*** *Institutions that have been added only to a site-specific Institution file, and entered in the PCMM Institution field, will cause HL7 transmission errors from AAC.*

(e) The PCMM patches SD\*5.3\*264, SD\*5.3\*278, and SD\*5.3\*272 and their associated patches, provided in the patch messages and documentation, are installed.

(f) The “PCDPC Guidelines for PCMM” in Attachment A is used to ensure that a correct “Direct PC FTE” is derived for each PCP.

(g) Each PCP’s direct primary care hours in the Decision Support System (DSS) is validated; that they are current, accurate, and comparable to PCMM’s “Direct PC FTE;” and that the accuracy of the data is maintained.

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(h) The “Direct PC FTE” for each PCP is entered. Maintain the accuracy of this data by updating the field whenever a PCP’s “Direct PC FTE” changes. This data must be entered through the Graphical User Interface (GUI) of the PCMM Software before May 23, 2003. The FTE Report, available only through PCMM Vista, must be used to identify personnel incorrectly identified as PCPs, e.g., residents, dietitians, social workers, administrative staff, etc. Only M.D.s, D.O.s, nurse practitioners, and physicians assistants may be PCPs.

(i) The “PCMM Enhancements for Direct PC User Guide” provides detailed instructions on entering the data and printing the “PCMM Direct PC FTE” report. It is available in the Vista Document Library at this website on the VHA intranet:

[http://www.va.gov/vdl/Vista\\_Lib/Clinical/Pri\\_Care\\_Mgmt\\_Module\\_\(PCMM\)/SD\\_53\\_277.UM-Final.pdf](http://www.va.gov/vdl/Vista_Lib/Clinical/Pri_Care_Mgmt_Module_(PCMM)/SD_53_277.UM-Final.pdf).

(j) The expected maximum panel size for each PCP in PCMM’s “Patients for Position: Allowed” field (404.51, .08) is entered by May 23, 2003.

(k) The transmission of the “Direct PC FTE” and “Patients for Position: Allowed” data is monitored at regular intervals with the “PCMM HL7 Transmission” option, “PCMM Reject Transmission Menu options,” Messaging Mail Groups for transmission status, checking the logical link for the HL7 messages, and checking the transmission queue.

d. **First line Supervisor of the Primary Care Providers.** Each first line supervisor of the Primary Care Providers is responsible for validating that the “Direct PC FTE” and “Maximum Panel Size” entered for their Primary Care Providers is accurate and updated when changes occur. A semi-annual verification of the “Direct PC FTE” and “Maximum Panel Size” fields is required.

**5. REFERENCES:** Implementation Guide and PCMM manuals are available on the Department of Veterans Affairs (VA) intranet at the web address, <http://www.va.gov/vdl/Clinical.asp?appID=95>.

**6. FOLLOW-UP RESPONSIBILITY.** The Office of the Deputy Under Secretary for Health for Operations and Management (VISN Support Service Center (VSSC) is responsible for the contents of this directive. Questions may be directed to (703) 476-8783.

**7. RESCISSIONS:** None. This VHA Directive expires May 31, 2008.

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Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 5/20/2003  
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 5/20/2003

## ATTACHMENT A

**PRIMARY CARE DIRECT PATIENT CARE GUIDELINES FOR  
THE PRIMARY CARE MANAGEMENT MODULE (PCMM)**

The Primary Care Direct Patient Care (PCDPC) Guidelines are business rules written to assist in establishing a uniform method of documenting Primary Care (PC) Time within the Veterans Health Administration (VHA) network. These Guidelines, written in response to the pressing need for consistent and accurate data, reflect the capacity of the system to make care available to patients. The most reliable way to collect data is for each facility to document direct patient care time and non-patient care time in the same manner. The PCDPC Guidelines reflect the method chosen by a group of physicians and Primary Care Management Module (PCMM) coordinators after a great deal of deliberation and discussion. The Primary Care Management Module will be enhanced to collect PCDCP Time in a new field called Direct PC Full-time Equivalent (FTE). When the individual sites load Primary Care Provider (PCP) Time into PCMM, data validation can begin.

***NOTE:** These Guidelines are not meant to determine how a facility staffs its clinics. The rules do not take into account the vast differences in staffing and physical structure experienced by different facilities. It is hoped that this first version of the Guidelines provides the kind of information needed to augment improvements in the delivery system of care. Once a standardized method of mapping hours is established, results can be expected to be diverse. The data will be evaluated and validated. At that time, revisions and modifications may need to be made to the document.*

**1. PURPOSE.** To provide clear and consistent guidelines to VHA PC Practices for the standardization of entry of data on PCP resources into the PCMM across all Networks.

**2. BACKGROUND**

a. The PCMM application assists facilities in implementing and managing primary care activities. Users may establish teams, assign staff to positions within a team, and assign patients to a team and to PCPs. The PCP and PC team information is captured in PCMM in the local database. Data rolled up to the national level is manipulated and is stored in the Austin Automation Center (AAC) for use in national reporting and performance measures.

b. The Assistant Deputy Under Secretary for Health, in a memo to the Chief Information Officer (CIO), February 1, 2002, expressed concern that “we do not know what our capacity is within the system to take care of patients who seek Department of Veterans Affairs (VA) care. One of the primary vehicles we use to assess capacity is the Veterans Health Information Systems and Technology Architecture (VistA) PCMM. This software is used to assign patients to PCPs and is an important component of waiting time reduction.” The memo set forth the task to include in PCMM the number of hours per week that the PCP is available to see patients in their primary care clinics.

c. A user group made up of physicians and PCMM users was formed to create a standardized definition for use to enter data on available PCP resources into the PCMM.

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d. While recognizing that there is no one best way to determine PC Clinic capacity, a decision does need to be made to specify which method will be used to collect data.

### **3. PROPOSAL**

a. This document proposes incorporating Decision Support System (DSS) guidelines into the definition of Primary Care Direct Patient Care (PCDPC). DSS already has an established set of guidelines for the definition of Direct Patient Care that can be made applicable to PCDPC. The advantage of using the DSS guidelines is that these guidelines have been in use and have been tested over time. They will provide a consistent characterization of direct care. For example, telephone care will be direct care in Veterans Integrated Service Network (VISN) 1, in VISN 13, and in VISN 16. The basis for entering PCDPC will be the same throughout the Networks.

b. Each facility will need to ensure that it has the DSS subgroup "Primary Care" under Direct Patient Care, and that this is used to map the time PCPs spent in taking care of primary care panels.

c. Incorporate the definitions of Administration, Education, and Research specified by DSS into the PCDPC guidelines.

d. Local facilities will continue to determine panel size for their individual providers. It is only on the local level that it is known what the level of support staff, space, team structure, etc., exists that may affect appropriate panel expectations. Because all facilities will be using the same definition of PCDPC, time allotted to non-direct care will be consistent (see par. 5).

e. Each facility will need to review their DSS mapping to ensure that activities of each clinician are allocated to the appropriate service. Many clinicians, for example, provide PC and specialty care services.

f. It is important to note that the disadvantage of using DSS guidelines is that DSS guidelines need modification to more accurately capture all clinician activities. When a problem with the guidance provided in the DSS guidelines is found, those issues should be referred jointly to DSS and to the Office of Primary and Ambulatory Care for resolution. Once there is resolution, this document should be revised.

### **4. ASSUMPTIONS**

a. Rather than adding up available hours, DSS works from the approach that a clinical provider's time is involved in those tasks that are necessary to provide clinical care. Resources are subtracted only if the individual is doing something that meets the criteria for exclusions to direct patient care (see par. 5). The definition of hours worked for a full-time PCP assumes that vacation time, sick time, break time, and other incidental times are taken into account when determining workload.

b. Available provider resources, as measured by PCDPC, are only one factor that can be taken into consideration when determining the expected panel for individual providers.

Numerous other factors, such as level of support staff, space, and administrative support and team roles, can legitimately affect the determination of an appropriate panel size. Expected panel size is determined at the local level and is not calculated automatically from PCDPC.

***NOTE:** This document should not be construed as the absolute final position, but instead serves to move multiple parts of the health care system toward the ultimate goal.*

c. DSS and PCMM are not integrated systems. Although comparisons of the data are not expected to match exactly, discrepancies between the two systems present the opportunity for validation that could reveal areas for improvement in either or both systems.

**5. DEFINITIONS.** The following definitions are taken from the DSS definitions of Direct Patient Care, Administration, Research, and Education.

a. **Direct Patient Care**

(1) Direct patient care is defined as the time to prepare, provide for, and follow-up on the clinical care needs of patients. This will include all time spent in reviewing patient data, discussions about the care with colleagues, reviewing the medical literature, and contacting the patient or caregivers to discuss their needs. In DSS, this time is allocated to various direct care departments in proportion to the time spent in each of these activities.

(2) **Examples**

(a) Time spent rendering care to a patient by physicians, nurses, residents, technicians, and other allied health personnel.

(b) Time spent in direct supervision of house staff providing direct patient care. For example, serving as an attending for a house-staff clinics.

(c) Time spent charting patient treatment, as well as ordering and reviewing patient tests and consultations.

b. **PCDPC**

(1) PCDPC is defined as the time to prepare, provide for, and follow-up on the clinical care needs of outpatient PC patients.

(2) PCDPC covers all those activities involved in providing PC to a panel of patients. These include:

(a) Time with patients and family in clinic.

(b) Review of patient records.

(c) Documentation of patient care.

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- (d) Telephone care.
- (e) Group clinics.
- (f) Discussion of patient care issues with consultants and other staff members.
- (g) Attendance at educational programs aimed at maintaining or improving clinical skills.
- (h) Participation in staff meetings that are focused on the delivery of PC.
- (i) Time spent in delivering patient care with medical students present.
- (j) Precepting residents while they deliver PC.
- (k) Precepting mid-level providers while they deliver PC.

(3) Activities that should not be mapped to PCDPC include the following:

- (a) Provision of specialty care to patients who are not in your PC panel.
- (b) Inpatient hospital care (even for the facility's own primary care patients). To maintain comparability across the system, the decision has been made that determination of PC panel size should be based on outpatient care only.
- (c) Activities that meet criteria for Administration.
- (d) Activities that meet criteria for Education.
- (e) Activities that meet criteria for Research.

**c. Administration**

(1) Administrative time includes time spent on managerial or administrative duties generally at the level of the service, medical center, or nationally, both within and outside VA. This time for professional staff is allocated as administrative time.

**(2) Examples**

- (a) Time spent in support of service-wide administrative activities, such as completing performance reviews, and medical center and VA Central Office reporting requirements.
- (b) Time spent managing a program within the service or hospital-wide.
- (c) Time spent working on service or hospital-wide committees.
- (d) Time spent working on medical school committees.

(e) Time spent serving on state and national committees, advisory boards, or professional societies.

d. **Education**

(1) Education is defined as time spent in formal training activities (didactic education) generally not directly involving patient care. This can include preparation and actual classroom or lecture time for educators or presenters. If the education is directly related to the staff's patient care responsibilities or an expectation of their supervisor to maintain their employment, it is considered the cost of direct patient care. For example, learning about the operation of new equipment in the cardiac catheterization laboratory or attending a mandatory Quality Management in-service session are both considered the cost of direct patient care activities and not education. In addition, time spent on house staff teaching rounds is considered the cost of direct patient care and not education.

(2) **Examples**

- (a) Time spent giving conferences in the community or nationally.
- (b) Time spent in classroom teaching medical school curriculum.
- (c) Time spent in classroom teaching of residents and fellows.
- (d) Time spent in managing a resident, fellow or student teaching program.

e. **Research**

(1) Research is defined as the time spent performing formal, approved research or in activities directly in support of approved research. Formal, approved research is research that either is approved through the hospital research review process or has the approval of the employee's service chief. Support activities include time spent by the investigator in direct support of research activities. Research can be laboratory, clinical or health services research.

(2) **Examples**

- (a) Time spent working in an actual research laboratory or controlled type setting that involves no direct patient care or treatment.
- (b) Time spent serving on hospital or affiliate research committees.
- (c) Time spent in supervision of student, resident or fellow research.
- (d) Time spent writing for publication.
- (e) Time spent attending meetings explicitly related to research activities.
- (f) Time spent presenting papers at research meetings.

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(g) Time spent sitting on a national study section or grant approving board.

**6. EXAMPLES OF MAPPING PCP'S TIME.** The following examples help illustrate how to map the time of PCPs with a range of different responsibilities.

**a. Full-time Primary Care**

(1) Dr. Jones is a full-time VA staff physician working in a Community-based Outpatient Clinic (CBOC). His clinical responsibilities consist entirely of providing outpatient PC to a panel of patients. He does not provide any specialty care or inpatient care. He is not responsible for managing any programs and does not serve on any medical center or VISN committees. He is not involved in any educational programs or research.

**(2) Dr. Jones should be mapped as 1.00 FTE PCDPC.**

**b. Administration**

(1) Dr. Sanchez is the Associate Chief of Staff for Ambulatory Care (ACOS/AC) at a VA medical center. She spends half of her time handling administrative responsibilities as ACOS/AC. She manages the outpatient programs and serves on a variety of medical center and VISN committees. She spends the other half of her time as a PCP and follows a panel of patients that is half the size of the full-time PCPs at her practice site. She does not provide any specialty care or inpatient care. She is not involved in any educational programs or research.

**(2) Dr. Sanchez should be mapped 0.50 FTE PCDPC and 0.50 FTE Administration.**

**c. Education**

(1) Dr. Shah is an academic primary care general internist working at a VA medical center affiliated with a medical school. He is the Clerkship Director for the third-year medical student Ambulatory Care rotation. He spends 1 hour per day giving a lecture to the medical students. In addition, he spends approximately 3 hours per week in various administrative tasks arising from this position, such as developing curriculum, planning schedules and attending meetings at the medical school. He spends the remaining 80 percent of his time providing primary care to a panel of patients that is 80 percent of the size of full-time PCPs in his practice. He provides no specialty or inpatient care and is not involved in research.

**(2) Dr. Shah should be mapped 0.80 FTE PCDPC and 0.20 FTE Education.**

**d. Research**

(1) Dr. Orlovsky is a VA staff physician who recently received a full-time Career Development Award in health services research. She continues to see patients and provide primary care to a panel of patients 1 day per week. The other 4 days per week she spends involved in her research activities. She provides no specialty care or inpatient care. She is not involved in any educational activities.

(2) **Dr. Orlovsky should be mapped 0.20 FTE PCDPC and 0.80 FTE Research.**

e. **Specialty Care**

(1) Dr. Li is a full-time VA staff physician who spends 50 percent of his time providing primary care to a panel of patients and 50 percent of his time as a pulmonary consultant providing consultation on patients followed by other PCPs. He is assigned a panel 50 percent the size of the full-time PCPs in his practice. He provides no inpatient care. He is not involved in any educational programs or research.

(2) **Dr. Li should be mapped 0.50 FTE PCDPC and 0.50 FTE to Pulmonary Medicine Direct Patient Care.**

f. **Inpatient Care**

(1) Dr. Smith is a full-time staff physician at a VA medical center that has an inpatient medical acute care unit. For about 6 months of the year, she serves as attending physician for one of the inpatient medicine teams. This activity takes about 4 hours per day so, when she is attending, she spends about 50 percent of her time on inpatient care and 50 percent on outpatient PC. During the 6 months when she is not attending, she spends full time providing care to her panel of PC patients. She follows a panel that is 75 percent of the size of full-time PCPs. She does not provide any specialty care and is not involved in any educational programs or research.

(2) **Dr. Smith should be mapped 0.75 FTE PCDPC and 0.25 FTE to Acute Inpatient Direct Patient Care.**

## 7. FREQUENTLY ASKED QUESTIONS (FAQs)

a. **“Administrative Time.”** The providers at our clinic are given ½ day per week where no patients are scheduled into their clinics. This allows them to catch up on telephone calls, filling out forms, writing letters, etc. We have called this “Administrative Time.” Should this be mapped to administrative time or to PCDPC?

**Response.** *It should be mapped to PCDPC. Administrative time includes the management of medical center programs or participation at medical center-, VISN-, etc., level committees. Providing primary care to a panel of patients involves a significant amount of activity outside of face-to-face time with the patients in the clinic office. The activities described for this “administrative time” relate to providing patient care to a panel of patients. These other activities are important components of direct patient care and should be included in the time mapped to PCDPC.*

b. **Telephone care.** Is time to return phone calls from my patients’ direct patient care?

**Response.** *Yes. Time to return phone calls or complete telephone follow-up for your patients is part of providing PC to a panel of patients and should be included as part of PCDPC. If you schedule a “Telephone Visit” with a patient in lieu of a face-to-face visit or create a*

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*“Telephone Visit Clinic,” this time is included in PCDPC hours. This type of visit or clinic is one of the high-leverage changes included in the Advance Clinic Access program and may serve to decompress a provider’s schedule and, in some cases, may save the patient from having to travel a long distance for a clinic visit.*

c. **Appointment length.** Does patient appointment length or the use of “carve outs” (open time without prescheduled appointments) for urgent visits affect the measurement of PCDPC?

***Response.*** No. PCDPC represents the net total of the time dedicated to providing PC to a panel of patients. Some providers find 15 or 20 minute appointments work best for their practice style and others find 30 minutes is needed. Some providers use “carve outs”(time in clinic is kept open for urgent visits) and others have all their time available in the scheduling package. In either case, the idea is to manage your patient panel, not visits.

d. **Mid-level supervision.** I have a certain number of hours set aside to supervise mid-levels while they provide care in the PC clinic. Should this be counted as PCDPC?

***Response.*** Yes. Mid-level supervision usually occurs one of two ways: either scheduled interaction time, or questions that are asked in the midst of the clinic day, between patient visits. In either case, it is time dedicated to the provision of PC to a panel of PC patients. Of note, in PCMM, a mid-level can be either a PCP, or an Associate Provider with a Precepting Physician. This decision is up to local discretion. If the medical center decides to have the mid-level as an Associate Provider, and the M.D. as the Precepting Physician, the patients would be included in the M.D.’s panel, as precepted patients, with the mid-level as the Associate Provider.

e. **Precepting Students and Residents in the Clinic.** Sometimes in clinic I have a medical student accompanying me while I see patients. I also spend ½ day per week precepting residents while they see patients in a residency PC continuity clinic. Should this time be mapped to education?

***Response.*** No. Even if students or residents are present, time spent providing direct patient care is mapped to Direct Patient Care. Education time should only include time that does not involve providing patient care. See definitions and criteria given in paragraph 5.

f. **CME.** Our staff generally spends an hour per week at a Medical Grand Rounds. The topics are clinical and related to their patient care responsibilities. Should these be mapped to education?

***Response.*** No. Continuing medical education that is related to direct patient care falls into the Direct Patient Care category. Education activities should include only those activities such as giving lectures or managing educational programs that do not involve providing care to patients. See the definitions and criteria given in paragraph 5.

g. **Level of Clinic Support.** There are two CBOCs at our medical center. In each CBOC, there is one full-time physician and one full-time nurse practitioner. At CBOC #A, there is a

high level of support staff. There are seven exam rooms, two for each of the providers and one for each of the support staff. The providers are allowed to dictate their notes. In CBOC #B, there is only one medical clerk, one room for each provider and no dictation. Should the amount of provider time in PCDPC be different in the two CBOCs?

**Response.** *No. In each CBOC, the amount of provider resources is the same: 1.0 M.D. and 1.0 NP. However, many factors affect the appropriate number of patients that should be in a provider's panel. The amount of support staff, space, and administrative support can affect the number of patients that a given provider can follow. Therefore, VA does not set a national policy on the specific number of patients that must be provided for each provider FTE. This is left as a local decision. Determination of the amount of provider resources, as measured by PCDPC, is only one factor that determines the appropriate panel size.*

h. **Staff Meetings.** Our staff meets on a regular basis to discuss management of the clinic. We review policies related to and problems encountered in delivering patient care. Should this be mapped to administrative time or direct patient care?

**Response.** *Conceptually, the administration category involves responsibilities and activities that are distinct from patient care responsibilities. Examples include time required to manage a program (writing policies, collecting Quality Assurance (QA) data, attending meetings, planning meetings, etc.). A certain number of team and staff meetings are required for communication among a team providing direct patient care. Staff meetings involving PCPs, which focus on the functioning of the clinic and the delivery of direct patient care, are most appropriately included in Direct Patient Care Time. It is acknowledged that sometimes the border between these activities is difficult to delineate and a degree of local decision-making and differentiation is allowed for such decisions.*

i. **Salary Source.** We have a career development award winner who spends 1 day per week providing care to a panel of PC patients. This physician's salary comes from a Career Development Award and is not part of our PC Service Budget. Should this individual's time still be mapped to PCDPC?

**Response.** *Yes. The key point is this individual's time is available to provide PC to a panel of patients. In some cases, the salary may be paid by other clinical services, by Research, by contract or the employee may even be a Without Compensation (WOC) volunteer physician. However, in all cases, the provider's time is available to provide PC to a panel of patients and thus should be included in PCMM as PCDPC, regardless of the source of their salary.*

j. **Mapping Medical Residents.** Our medical residents spend ½ day per week in the clinic. Should their time be mapped as physician time?

**Response.** *No. Each resident must have a precepting physician. The time of the precepting physician should be mapped to PCDPC. However, residents are a different category and their time should not to be included for the purposes of provider resource mapping for PCMM.*

k. **Mapping General Internal Medicine Fellows.** We have a general internal medicine fellow at our medical center. He spends 1 day per week following a panel of PC patients. He

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has completed his Medicine Residency Program and is board-certified in Internal Medicine. Should his time be mapped as physician time?

**Response.** *No. VA has decided that all staff that are being paid as house staff by VA must have a precepting physician. General internal medicine fellows are unique in that they are already board-certified in the field in which they are receiving advanced training. This particular situation is a “gray area,” but VA has decided that they should not be considered staff physicians and should be mapped in the same way as residents.*

l. **Contract Clinics.** We have a CBOC that provides PC under a contract. Should these patients be entered into PCMM and how should we handle the mapping of provider resources and expected panel?

**Response.** *VA would like all patients being provided PC to be entered into PCMM and assigned a provider and team. This is true for contract PC services as well as services provided by VA staff. Therefore, in the case of a contract clinic, a PCMM team should be created and these patients enrolled into that team. A best estimate of the provider FTE and the number of patients that can be followed at that clinic should be made and entered into PCMM.*

m. **Women’s Clinic.** How do I account for Women’s Clinic?

**Response.** *It depends upon whether the Women’s Clinic in question is providing PC or specialty care. Some women’s clinics serve as PC clinics, providing ongoing PC for women, including preventive care and care for common outpatient gynecological problems. (NOTE: The scope of Women’s Health PC is defined in the VHA Handbook 1330.1, VHA Services for Women Veterans.) Such clinics should have the DSS clinic stop code 322, and the provider’s time included in PCDPC. Other Women’s clinics function as specialty consult clinics for Obstetrics (OB) and/or Gynecology (GYN) problems. A specialist evaluates problems outside the scope of the patient’s PCP’s expertise. Such clinics should have the DSS clinic stop code 404.*

n. **Inpatient Attending Months.** At our medical center, many PC physicians spend 2 months per year as an inpatient attending. Should the amount of time mapped to PCDPC be changed for those 2 months, or can we average it over the year?

**Response.** *For many providers, their responsibilities can change from month to month. Providing PC involves establishing an ongoing relationship, and the expected panel size cannot be expected to change from month to month. In most institutions, responsibilities such as these are assigned on a yearly schedule. It is better to consider time allocation on a yearly basis.*

**ATTACHMENT B**

**TRANSMISSION OF PROVIDER WORKLOAD TO THE  
AUSTIN AUTOMATION CENTER (AAC)**

1. The patch, SD\*5.3\*272, provides for transmission of provider workload to the Austin Automation Center (AAC). The message is generated at the same time the current Primary Care Management Module (PCMM) HL7 messaging is run. **NOTE:** *This is usually a nightly scheduled task.*
2. A post-installation routine reviews existing active providers with Full-time Equivalent (FTE) workload information, "Direct FTE" field, and the maximum panel size, "Patients for Position: Allowed" field, and triggers them for transmission. The Primary Care Provider (PCP)'s "Institution" and "Person Class" will also be transmitted. It is imperative that only institutions that are in the nationally utilized "Institution" file be entered in PCMM. If locally named institutions, i.e., those that are not in the national file, are used, transmission errors will occur.
3. A soon-to-be-released patch, SD\*5.3\*280, will prevent entry of institutions not in the nationally utilized "Institution" file (4).
4. A pre-initialization routine will set up a B02 HL7 event in file 779.001.

a. **Protocols Transported**

**SCMC LE DESELECT PATIENT** Select Record(s) for Retransmit.

**SCMC LE RETRANSMIT PATIENT** Deselect Record(s) for Retransmit.

Renamed for enhanced capability of handling current HL7 Transmissions, which are not Patient centric.

**SCMC SEND CLIENT WORKLOAD** PCMM SEND CLIENT FOR WORKLOAD

**SCMC SEND SERVER WORKLOAD** PCMM SEND SERVER FOR WORKLOAD

Used for sending Message and receiving acknowledgments.

b. **Mail Group.** A new mail group is transported in this package PCMM WORKLOAD FTEE MAIL GROUP. It requires that [XXX@Q-NPD.MED.VA.GOV](mailto:XXX@Q-NPD.MED.VA.GOV) be included as a remote member to receive HL7 messages.

c. **File Changes**

(1) **PCMM HL7 TRANSMISSION LOG (#404.471).** Added new field WORKLOAD EVENT POINTER (#. 07) to track HL7 error Messages.

(2) **PCMM HL7 ERROR CODE (#404.472).** Addition codes for HL7 error messages.

(3) **PCMM HL7 EVENT (#404.48).** WORKLOAD (#. 08) field added to differentiate workload messages.

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(4) **POSITION ASSIGNMENT HISTORY (#404.52).** Cross-reference added to track practitioner and position changes.

(5) **TEAM POSITION (#404.57).** Cross-references added to track maximum workload and primary care position designations.

(6) **TEAM POSITION HISTORY (#404.59).** Cross-reference to track team inactivation.

(7) **HL7 APPLICATION PARAMETER.** PCMM is transported to transmit HL7 messages to AAC.

(8) **HL7 LOGICAL LINK.** PCMM WORK is transported to transmit HL7 messages to AAC.

**NOTE: A new DOMAIN entry is required for this patch**

NAME: Q-NPD.MED.VA.GOV                      FLAGS: S  
DHCP ROUTING INDICATOR: PCM  
NETWORK NOTES: Transmit PCMM FTEE